



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED
AND
DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

I. UNDERSTANDING YOUR HEALTH INFORMATION

Each time you visit our community health center, we create a record of your visit. This record usually contains your name and other information that may identify you, your symptoms, examination and test results, diagnoses, treatment, plan for future health care, and financial information. This record is sometimes referred to as your “medical record” or “medical chart.” This record allows:

Doctors, nurses, and other health professionals to plan your treatment;

Our community health center to obtain payment for services we provide to you from health plans, Medicaid, or you; and

Our community health center to measure the quality of care provided to you.

As in the past, we are committed to keeping your health information confidential. We are required by law to maintain the privacy of your health information and to inform you of our legal duties and privacy practices with respect to your health information. We are required to abide by the terms of this notice, although we reserve the right to change the terms of this notice and will provide you with a revised version via our websites or in

person should the terms change. You may request a copy of the current notice at any time. We will not use or share your health information without your written permission, except as stated in this notice.

II. HOW WE WILL USE AND GIVE OUT YOUR HEALTH INFORMATION

A. TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

We will use and share your health information to provide you with health care treatments, to get paid for our services, and to help us operate our community health center. For example:

We will share your health information with health care professionals not on our staff, such as other healthcare providers and hospital staff, who help care for you. This information may be shared via fax, paper or electronic formats. We also participate in an organized health care arrangement and a health information exchange (Colorado Regional Health Information Organization or CORHIO) that enables healthcare providers to share a database containing your health information for treatment purposes and enables the delivery of better, more efficient care to you. However, you may opt out of participation in CORHIO at any time by notifying our staff, who will

then provide you with the forms to do so.

We may send a bill to your health insurance plan or to you to obtain payment for services rendered.

We may use your medical record to review our performance and make sure you receive quality health care and/or to conduct training or compliance functions/activities.

B. OTHER USES AND DISCLOSURES ALLOWED OR REQUIRED BY LAW

We may use or disclose your health information for the following purposes under limited circumstances:

To people who are involved in your care or who help pay for your care (e.g., your family, close personal friends, or any other person chosen by you) to notify them of your location, general health, and to assist you in your health care (such as to pick-up medicine or help with follow-up care);

To government agencies that oversee our community health center (such as license and certification inspectors), and/or for specialized government functions, such as military and veteran's activities, national security and intelligence activities, and protection of public officials;

To government agencies that have the right to receive and collect health information (such as to control disease outbreaks). We also share health information with the Colorado Immunization Information System (CIIS), which is a confidential database housing immunization data for Coloradans. You may opt out of participation in CIIS at any time by notifying our staff, who will provide you with the forms to opt out;

When we are ordered by a court or judge;

To workers' compensation programs when your health problem is from a work-related injury;

When law enforcement requests information (such as to prevent danger or injury);

To report information related to victims of abuse, neglect, or domestic violence or other public health-related permitted uses or disclosures;

To coroners and funeral directors to allow them to carry out their duties upon your death, and/or for cadaveric organ, eye, or tissue donation and transplantation purposes;

To organ donor agencies (subject to applicable laws);

To avoid a serious threat to the health or safety of yourself or others;

To notify or assist in notifying your family, a personal representative, another person responsible for your care, or disaster relief authorities of your location, condition, or death.

To contact you about appointment reminders, new treatments, or medicines that may help you;

For the purpose of research under limited circumstances;

Through business associates or other contractual arrangements. Some services in our organization are provided through contracts and/or agreements with business associates and other healthcare organizations. Examples include physician services in the emergency department and radiology, mental health services, laboratory and diagnostic services, and other organizations who help to improve

the quality of your health and healthcare experiences or assist with our back-office operations (e.g., billing, information technology, etc.). When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do. So that your health information is protected, we require business associates to safeguard your information appropriately.

We may use medical information about you to contact you in an effort to raise money for the clinic and its operations. If you are contacted in our fundraising efforts, you will have the opportunity to opt out of receiving further fundraising communications from us.

For any other purpose required or permitted by law.

C. OTHER USES AND DISCLOSURES REQUIRING YOUR WRITTEN PERMISSION

Except as stated above, we will use or give out your health information only after obtaining your written permission on an authorization form. You may revoke your authorization at any time by notifying us in writing that you wish to do so.

III. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Subject to certain legal limits, you have rights regarding the use and disclosure of your health information, including the right to:

Request limits or restrictions on uses of your health information in certain circumstances. However, we are not required to comply with requests in all cases. To request restrictions, you must make your request in writing to Clinica's HIPAA Privacy Officer. In your request,

you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply.

Receive confidential communications about your health information.

Inspect and copy your health information.

Request a change or amendment to your health information.

Receive a record or accounting of how we have used or disclosed your health information.

Obtain a copy of this Notice of Privacy Practices.

You have the right to receive notice from us of a breach of your unsecured protected health information.

IV. QUESTIONS, CONCERNS, OR COMPLAINTS

If you have any questions or wish to discuss any of the information in this Notice of Privacy Practices, please contact the HIPAA Privacy Officer at 1735 S. Public Rd., Lafayette, CO, 80026. You can also call our HIPAA Privacy Officer at (303) 650-4460.

If you believe your privacy rights have been violated, you may file a complaint with our community health center or the Secretary of the Department of Health and Human Services. To file a complaint with our community health center, submit a written statement to the HIPAA Privacy Officer at 1735 S. Public Rd., Lafayette, CO, 80026. For information on how to file a formal HIPAA privacy complaint directly with the Department of Health and Human Services go to: <https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html>. We will not retaliate against you for filing a complaint.



Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, acknowledge receiving and
name

reading a complete copy of the Notice of Privacy Practices of Clinica Family
date

Health on _____. I further acknowledge that, as of today's date,

I have no questions regarding the Notice of Privacy Practices.

[Place patient label here]

Name	Date of Birth	Account #